STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475053	A. BUILDING _____ B. WING _____	10/07/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO HEALTHCARE INC.	71 RICHARDSON AVE NORTHFIELD, VT 05663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted by the Division of Licensing & Protection on 10/5/09-10/7/09.	F 000	The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of our residents lives.	11/7/09
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to revise the comprehensive care plan to reflect the current needs of 2 of 26 residents. (Residents #10 and #16). Findings include: 1. Per record review, on 10/7/09, Resident #16's care plan was not revised to address a dental	F 280		

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OCT 26 2009
DIVISION OF LICENSING

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christine Scott	Administrator	10/23/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 issue that was identified on 9/25/09. A nurse's note, dated 9/25/09 at 2:50 PM, stated "Resident c/o gum pain. Has open area ... ..." A fax to the physician, on that same date, stated, "Resident has open area approx 0.5 cm x 0.5 cm on lower right gum. Will make dental appt. May we use aragel PRN and keep teeth out between meals." The physician's faxed "yes" response was also dated 9/25/09. Following a dental appointment on 10/5/09 a nurse's note at 4:00 PM on that date stated; "Appt with Dr. ..... today. Resident c/o pain from partial. Dr. ..... made adjustment and said to continue removing partials she has been doing after meals and at night." During interview, at 9:10 AM on 10/7/09, the Nurse Unit Manager confirmed the lack of care plan revision to reflect the resident's dental needs. 2. Per interview and record review, staff failed to revise the Nutritional care plan to reflect Resident #10's specific food and snack preferences. Per interview on 10/05/09 at 11:55 AM Resident #10 stated that she has asked the facility to bring breakfast later than they have been (8:30 AM), only sweet breads and coffee for lunch and a light meal for supper. Per record review on 10/6/09, Resident #10's care plan stated 'hot breakfast 9-9:30 AM, light lunch or snack and regular supper, provide substitute for meals'. Per interview on 10/07/09 at 9:45 AM the dietician stated that the resident does only eat sweet breads/coffee for lunch and that breakfast should be later in the morning. In addition, although supper is a regular diet, light fare such as a fruit plate would be acceptable. Per interview on 10/07/09 at 11:00 AM the DNS confirmed that the	F 280	The cited comprehensive care plans for 2 of 26 residents have been updated to include the current needs for dental care for Resident # 16 and for specific food preferences for Resident # 10. Since all residents have the potential to be affected by the same deficient practice, the care plan team members will be educated by DNS, Staff Development Coordinator or designee on the importance of updating care-plans in a timely manner. To ensure that staff remain aware of this potential for deficient practice care-plans will be audited weekly by the DNS or designee. Any omissions will be researched & corrected. Education will be provided to those involved. Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.	11/7/09

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F 280	Continued From page 2 care plan had not been revised to reflect the resident's choices for food.	F 280		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to assure that care and services were provided in accordance with physician orders and professional standards of nursing practice for 5 of 26 applicable residents. (Residents #6, #10, #20, #33 and #43). Findings include: 1. Per record review staff failed to follow up on a pharmacy recommendation regarding dose reduction of a psychoactive medication for Resident #6. A pharmacy consult to the resident's physician, dated 3/10/09, stated that the resident had been on the current dose of Trazodone (an antidepressant) 50 mg since December 2007, and requested a reassessment of the dose to determine if dose reduction was appropriate. Although the physician's response stated "sure go ahead" s/he did not identify what dose to administer and there was no evidence of follow up to determine the dose until 4/2/09 when a fax to the physician, initiated by nursing, stated; "We need a specific order for the trazodone dose that you want." Following the 4/2/09 fax there was no evidence of any response by the physician or any further follow up and the resident remained on the 50 mg dose as of 10/06/09. During interview, on the morning of 10/7/09, the	F 281	The Pharmacy recommendation to reduce Trazadone for Resident # 6 has been clarified and the dose has been reduced from 50 mg to 25 mg. All residents have the potential to be affected by the same deficient practice, therefore, the DNS and Consulting Pharmacist will meet monthly to assure that all Pharmacy recommendations have been addressed completely. A QAA study will be developed to review and audit Pharmacy recommendations on a routine basis by the Administrator &/or members of the QAA team. Any omissions will be researched and corrected, if found. Education will be provided to those involved. Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.	11/7/09

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F 281	Continued From page 3 DNS (Director of Nursing Services) confirmed the lack of follow up by staff to the pharmacist's recommendation for dose reduction of the psychoactive medication. 2. Per observation on 10/06/09 at 12:00 Noon staff failed to provide care in accordance with professional standards of practice. Staff administered eye drops for Resident #43 by using the same single-use vial multiple times during the day. In addition, during the evening med pass, the same single-use vial was noted to be stored in the bottom of the med cart, in a plastic cup, touching other items. Per interview on 10/07/09 at 11:00 AM the DNS confirmed staff failed to follow standards of practice. 3. Per interview and record review, staff failed to monitor weekly weights for Resident #10 who had an 11 lb. weight loss in 7 weeks. Per record review on 10/06/09 the care plan directed staff ; "weights weekly on bath day, re-weigh if up or down 3 lbs. Per review of the weight book and bath book, Resident #10 weighed 118 lbs on 8/17/09, 116 lbs on 8/25/09, 112 lbs.on 9/06/09, (which had no re-weight documented for greater than 3 lb loss), 114 lbs on 9/13/09, and 107 lbs on 9/24/09 (again no re-weight was documented). The weights were not documented for the week of 9/17/09, 9/29/09 and 10/6/09. Per interview on 10/07/09 at 9:45 AM the dietician confirmed that the weights and the re-weights were missing. Per interview on 10/07/09 at 11:00 AM the DNS confirmed that staff failed to monitor weekly weight for Resident #10 who had weight loss. Reference: Nettina, S.M. (2006). Lippincott	F 281	2. The practice of using single-use eye drop vials was immediately stopped. All residents have the potential to be affected by the same deficient practice, therefore, single-use containers will only be used once and then discarded. All licensed RNs and LPNs and our contracted Pharmacy has been informed that despite the Physician's approval to use single-use medications more than once, Mayo will follow the manufacturer's recommendation for only one dose. The DNS, Unit Manager, Pharmacy Consultant or designee will conduct random checks of the medication administration carts to assure that all single-use vials are being used according to the manufacturer's recommendation. Any violations of this practice will be immediately addressed and corrected. Education will be provided to those involved. Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.	11/7/09

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F 281	Continued From page 4 Manual of Nursing Practice 8th Edition, Lippincott, Williams & Wilkins, Philadelphia 4. Per observation on 10/5/09 at 3:52 PM, Nurse #1 failed to provide care in accordance with professional standards of practice. Per observation, Nurse #1 prepared and administered oral medications to Resident #20 after direct contact with Resident #33, and did not wash or sanitize hands in between residents. Nurse #1 performed a fingerstick on Resident #33 wearing gloves, s/he then removed the gloves and without washing hands, drew up and administered a subcutaneous injection of insulin, touching the resident's body with bare hands during the procedure. Nurse #1 then left the room of Resident #33, proceeded to the medication cart and prepared medications for Resident #20. The nurse then entered the room of Resident #33 and administered the oral medications without washing hands prior to administration. The nurse confirmed the above observation on 10/5/09 at 4:00 PM and 4:05 PM. Reference: Boyce, John M.; Pittet, Didier. Guideline for Hand Hygiene in Health-Care Settings. Centers for Disease Control and Prevention, October 25, 2002 (accessed October 8, 2009). http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm	F 281	3. Staff involved in the stated deficient practice for monitoring weekly weighs for Resident # 10 have been educated. Resident #10 has been weighed and showed a four pound increase in weight to 111#. Since all residents are potentially at risk for this deficient practice the DNS, Staff development Coordinator or designee will educate all nursing staff on the importance of obtaining weekly weights and monitoring changes. The DNS, Unit Manager or designee will conduct random audits to be sure weights are completed and monitored appropriately. Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. 4. The nurse who failed to wash or sanitize her hands in between residents has been re-educated as to the importance of following appropriate hand-washing practice. All residents have the potential to be affected by the same deficient practice, therefore, this nurse will be randomly observed and monitored for following appropriate hand-washing practice.	11/7/09
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all			

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F 431	Continued From page 5 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to assure that all drugs were stored safely and under proper temperature controls. Findings include: 1. Per observation and record review the facility failed to store all drugs in accordance with the manufacturer's instructions for recommended temperature range. On the morning of 10/6/09,	F281 F431	4. (cont.) Additionally, this nurse will work in conjunction with the Staff Development nurse to conduct an In service on using the latest CDC guidelines for hand-washing or the use of hand sanitizers when appropriate. Results of the random observations will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. F431 A thorough review of any and all medications that require refrigeration was conducted and it was determined that no medication was adversely affected by the temperature of 34 degrees for 5 days. The temperature log sheet has been revised to reflect the manufacturer's instructions for recommended temperature range of between 36 and 46 degrees. Our Pharmacy Consultant will alert Mayo at any time that we add any medication that requires different temperature ranges according to the manufacturer's recommendations for storage.	11/7/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 6 during inspection of the medication room, the thermometer inside the medication refrigerator registered at 32 degrees Farenheit. Medications stored in the refrigerator, at that time, included multiple vials of Flu Vaccine, Hepatitis B Vaccine and Tubersol, all of which had manufacturer's directions to store at a temperature between 36 and 46 degrees. Per record review, the facility's 'Refrigerator Temperature Log Sheet' (Med Room) identified that the temperatures should fall between 34 to 40 degrees and the temperature of the medication refrigerator was recorded at 34 degrees Farenheit for 5 of the 6 days of October. The consultant pharmacist and the DNS both confirmed, during interview at that time, that the temperature range of 34-36 degrees, identified in the facility policy as the appropriate storage temperature for all medications stored in the refrigerator, was not congruent with the manufacturer's temperature storage recommendations for the above stated vaccines.	F 431	F 431 The written recommendations received from the Pharmacy Consultant monthly and given to the DNS will include a statement that the refrigeration logs have been reviewed each month and found to be in compliance. Any variances will be corrected immediately. The QA Committee will review the monthly temperature logs to assure that the refrigerator temperatures are consistently in compliance. The frequency and duration of the review of these logs will be determined by the committee.	11/7/09 11/7/09
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by:	F 441	The nurse who failed to wash or sanitize her hands in between residents has been re-educated as to the importance of following appropriate hand-washing practice. All residents have the potential to be affected by the same deficient practice, therefore, this nurse will be randomly observed and monitored for following appropriate hand-washing practice. Additionally, this nurse will work in conjunction with the Staff Development nurse to conduct an In service on using the latest CDC guidelines for hand-washing or the use of hand sanitizers when appropriate.	11/7/09

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F 441	Continued From page 7 Based on observation, staff interview and record review the facility failed to assure that appropriate infection control practices were implemented by all staff. Findings include: 1. Per observation on 10/5/09 at 3:52 PM, Nurse #1 prepared and administered oral medications to Resident #20 after direct contact with Resident #33, and did not wash or sanitize hands in between residents. Nurse #1 performed a fingerstick on Resident #33 wearing gloves, s/he then removed the gloves and without washing hands, drew up and administered a subcutaneous injection of insulin, touching the resident's body with bare hands during the procedure. Nurse #1 then left the room of Resident #33, proceeded to the medication cart and prepared medications for Resident #20. The nurse then entered the room of Resident #33 and administered the oral medications without washing hands prior to administration. The nurse confirmed the above observation on 10/5/09 at 4:00 PM and 4:05 PM 2. Per observation, on 10/06/09 at 12:00 PM, the nurse failed to prevent possible cross-contamination of single-use medication while administrating eye drops for Resident #43. Following the administration of eye medication to the resident the opened single-use vial of eye drops was placed, uncovered, in a plastic cup next to another, uncovered, single-use vial, and then stored in the bottom of the med cart for future use. Per interview, at that time, the nurse stated that nursing staff administer 2 different eye medications to the resident, reusing each of the 2 single-use vials multiple times during the day. The nurse further stated that the resident had requested that the single-use vials be reused to	F 441	Results of the random observations will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. The practice of using single-use eye drop vials was immediately stopped. All residents have the potential to be affected by the same deficient practice, therefore, single-use containers will only be used once and then discarded. All licensed RNs and LPNs and our contracted Pharmacy has been informed that despite any Resident's request to use a single-use vial more than once, Mayo will follow the manufacturer's recommendation for only one dose. The DNS, Unit Manager, Pharmacy Consultant or designee will conduct random checks of the medication administration carts to assure that all single-use vials are being used according to the manufacturer's recommendation. Any violations of this practice will be immediately addressed and corrected. Education will be provided to those involved.	11/7/09

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F 441	Continued From page 8 save money. Per observation, during the evening med pass, on that same day, the same single-use vial was noted to be stored in the bottom of the med cart, in a plastic cup, touching other items. Per interview on 10/06/09 at 1:00 PM, the pharmacist stated that single-dose vials should be used only once and that the [eye]medication comes in a multi-use bottle. Per interview on 10/07/09 at 11:00 AM the DNS confirmed staff failed to follow recommended guidance and policy on single-use medications.	F 441	Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.	11/7/09